ROYAL FREE LONDON

Responses to Healthwatch Barnet Hospital Discharge Report

1. **For hospital providers to confirm their commitment to ensuring consistency in the care that is provided to patients and that every patient has a right to good nursing care experience. Providers should make it clear to patients and their carers on admission and discharge the standards of care that they should be able to expect.**

   RESPONSE: The Royal Free NHS Foundation Trust is committed to ensuring a consistency in high quality of nursing care across all sites and within all clinical areas. Our mission is to deliver world class expertise and local care. The values we have developed are around ensuring that we are welcoming, respectful, communicating and reassuring.
   The mission and values are communicated to patients, carers and staff so that their expectation will be around consistently high standards of care.

2. **That hospitals improve communication between professionals and patients and their carers. Patients to be asked whether they would like their family/carers to be involved in discussions and decisions relating to discharge and if so, for this to be a planned part of the system. Patients should have clear explanation of when professional hospital staff may need to contact carers or families without the patients' express permission (such as if the patient wishes to discharge him/herself against medical advice).**

   RESPONSE: To assist in communication at all levels for a patient's care, the flow coordinators (currently in post at Barnet hospital and the same model being rolled out at the Royal Free site) and the ward staff converse with patients and carers at admission. We use the Ticket Home programme (established six months ago at the Barnet and Chase sites) to explain what is happening. This will also be rolled out at the Royal Free site with the flow coordinators implementing.

   What is Ticket Home?

   - Ticket Home is a checklist-like tool that facilitates communication among many disciplines.
   - It is a laminated card that is placed at the patient bedside, with sections for multidisciplinary input (e.g. Physiotherapy, Occupational therapy instructions), information about whether the patient requires transportation home, whether their medication reconciliation has been done and follow up appointments scheduled,
   - Planned date of discharge is set on admission and communicated to the Patients and relatives, and must be updated regularly

The Aim of Ticket Home

- Helps both the patient and the family better understand what to expect during the hospital stay and anticipate what goals need to be met to enable the expected date of discharge to be met
- Aim to strive to meet the anticipatory goals ahead of time – by showing patients when and where they will discharged, and involving them in their care
- The anticipated date of discharge is also very helpful for the patient's family or other caregivers. They can plan their availability around that anticipated date.
- It may be more difficult to anticipate the date of discharge for many medical admissions, but the concept of Ticket Home should still be adopted, this will improve ward organization

Morning Discharges

- Discharges should be planned for the morning, enabling medically fit patients to settle into the home environment much earlier in the day
- GPs, District Nurses and Home Care staff are more likely to be available
- Staffing levels may be higher in the morning allowing for a more effective information exchange with patient/and or carers
- Delayed morning discharges will have a cascade effect of admissions from A and E or transfers from ITU. Bottlenecks may be created due to lack of bed availability.

Discharge to the Discharge Lounge

- The discharge lounge must be used if the patient is considered suitable for the lounge. This information will be displayed on the Ticket Home
- Patients/ Relatives and Carers must be informed that it is expected that discharges will occur before 11am, and if the patient is waiting for transport or relatives they will be asked to wait in the lounge.

What next

- The Ticket Home, individualised for each ward needs is laminated for each patient, the individual ticket should also be given to patient/ carer
- The Ticket home should be placed on the patient's locker or behind the bed head
- Each patient should have a completed form
- Day of actual discharge should be recorded against PDD set.

Whilst we can appreciate the request that carers or families are contacted without the patient's permission, we do have a duty of care to the patients to respect their privacy.

Unless a patient doesn't have capacity we cannot go against their wishes about contacting next of kin. For patients that do not have capacity, we act in their best interest in terms of discharge planning.

3. **In some cases the keenness of some patients to get home is a contributory factor in a poor discharge, as is the hospital's over reliance on the informal carer to take too much responsibility; the hospital should be able to check with the informal carer that all is in place for an appropriate discharge. If enablement is not in place when the patient leaves hospital, it is very difficult to arrange once they are at home.**

   RESPONSE: Patients should always be asked for their agreement to contact formal or informal carers. When they agree for this, this is done by the ward staff. Similar to discharge arrangements, patients without capacity will be acted on by the ward in the patients' best interest.

   To determine care needs for patients in preparation for their discharge, all patients are risk scored using a standardised national tool. In the case of an emergency admission, this is done as soon as possible after admission. For a planned admission (e.g. a planned surgical procedure) this is done at preadmission.

   The risk tool is to guide when the patient should be referred to social care for an assessment of their care needs (this is called a section 2 notice). Within 24hours of a receipt of a notice to assess, the social worker for the borough that the patient lives should assess and discuss post discharge care arrangements with the patient. Patients with capacity can opt out of a social care assessment.

4. **For Doctors and Consultants to maintain compassion and understanding whilst liaising with patients and their families.**

   RESPONSE: All clinicians are committed to maintain compassion and understanding whilst liaising and communicating with patients and their families and their carers. We want all patients to feel confident, safe and well carer for and reassured that they are in safe hands.

5. **To reduce waiting periods for discharges by improving medication and transport arrangements coordination.**

   RESPONSE: The introduction of flow coordinators has been a key enabler in our Home For Lunch programme. As the name suggests, this is all about a morning discharge to get patients back to their usual place of care by lunch.

   Home for Lunch is in place at Barnet and Chase sites and is for roll out to the Royal Free site in early 2015. The key objective was to increase the number of patients that are discharge safely before lunchtime, thereby reducing length of stay by improved discharge planning and process. The project has included significant service transformation e.g. pharmacy hours.

   Discharge processes have been improved by ensuring that all staff groups and external providers of health or social care understand the need for timely discharge of patients from hospital

As with all projects, the delivery was via a detailed transactional project plan which included milestones, timelines and given responsibility defined

Four Matrons across the Barnet and Chase site were identified as the key project leaders, along with a project manager from the Quality, Innovation and Productivity team. These key people were responsible for ensuring that targets were met and key actions delivered – where a key task or action was at risk in terms of delivery, mitigation reports are submitted and immediate action taken.

Initially the Home for Lunch project involves 5 wards across Barnet and Chase sites -Cambridge and Canterbury at Chase Farm & Cedar, Juniper and Quince at Barnet

This is now across all wards on the two sites.

The key benefits of Home for Lunch have included

- Increased patient satisfaction
- Community services available at an optimum time
- Social Services available at an optimum time
- Bed capacity is released – thereby Emergency department waits for beds reduced significantly

6. **To give enough notice to patients' family regarding patient's discharge date and time.**

   RESPONSE: Planned discharge dates (referred to as PDDs), are included as part of Ticket Home.

   The PDD needs flexibility to reflect changing patient needs. We are currently planning an audit for the first quarter of 2015 to look at how many PDD change (either move forward or back) and the reasons for this.

   Changes to PDD should be communicated to the patient by the ward and be available for families and carers via the Ticket Home.

7. **To encourage discharges before 6pm, and avoiding late evenings and night discharges.**

   RESPONSE: The key priority as detailed above is Home for Lunch. This is a key enabler to proactive improvements in hospital flow.

8. **To improve the planning of patients' after care plan by listening to patients' concerns and wishes.**

   RESPONSE: We actively work with our partner organisations in planning for a patient's discharge home. A good example of joint hospital, community and social care integration in joint discharge planning is the Post Acute Care Enablement service (PACE).

PACE has been in place at the Royal Free site for 5 years now and supported over 6500 patients across Barnet and Camden. The same model was implemented for the Barnet and Chase sites a year ago to support patients from Barnet and Enfield and plans are progressing for Hertfordshire patients too.

We want as many of our patients and their families and carers as possible to participate in their discharge planning. We will use the additional information and responses in the Healthwatch report to inform this process.

9. **To offer rapid and easy access to independent advocacy services on wards and on discharge.**

   RESPONSE: We work with both internal and external agencies so that we can provide access to advocacy services on the wards and on discharge .Our PALS service is an important point of access for patients on all 3 sites.

10. **Lastly, although, it was not one of the objectives of this consultation to identify how many patients had neither family nor friends, out of 124 patients that were spoken to, it was noted that at least 40% either had no family or friends or had family who lived far or had conflict within the family. It is critical for the discharge team to consider that elderly patients may not always have family or friends and plan discharge, including liaison with social care and voluntary organisations, accordingly. Communication about the Enablement Package could be improved.**

    RESPONSE: We fully appreciate that patients may not have any direct family or have reasons why their family does not wish to be involved in their care.

    All patients are offered the opportunity for an assessment by social care for care needs on discharge.

    Our therapists should always be involving patients in their onward care needs.

    For patients who do not meet the threshold for social care (or choose not to want their involvement), we do offer referral to third sector support services that we work directly with. This includes the option of referral to British Red Cross who can support with befriending and simple tasks such as shopping for patients on a short term basis.